STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

March 20, 1984

To: All County Welfare Directors

Letter No. 84-9

BELTRAN V. MYERS

Reference: All County Welfare Directors (ACWD) Letters 83-43, 83-51, 83-55 and 83-58

This Letter is to provide you with procedural changes ordered on March 5, 1984, by the United States District Court in Beltran v. Myers. These changes are effective March 20, 1984, and must be implemented immediately.

1. For potential class members who have not yet been sent a court-ordered Beltran notice, the county shall, upon identification, send the court-ordered notice, the Beltran application, six new Beltran claim forms (Attachment I), and the new Beltran Application Instructions (Attachment II).

2. For potential class members who have been sent the court-ordered Beltran notice, and are still within the 90-day time limit for response or who have responded but the county has not yet sent a Beltran application, the county shall send the Beltran application, six new Beltran claim forms, and the new Application Instructions.

3. For potential class members who were sent a Beltran application, but as of March 20, 1984, had not returned the application, the county shall send six new Beltran claim forms and the Claim Instructions explaining the change in procedures.

4. The individuals specified in (1), (2), and (3) above will have a total of 180 days from the date they receive the new Beltran package to complete and return the application and claim forms.

5. The county must process the application within the time limits specified in Title 22, Section 50177.

6. The county shall have 20 days from the date a completed claim form is received or 20 days from the determination of eligibility, whichever is later, to transmit the completed Beltran claim to the Department of Health Services (DHS).

   Example 1: Completed application and claim forms received March 30, 1984. Eligibility approved April 20, 1984. County must transmit claim forms to DHS by May 10.

   Example 2: Completed application received March 30, 1984. Approval notice issued April 20, 1984. Completed claim forms received May 10, 1984. County must transmit claim forms to DHS by May 30, 1984.

This order requires modification of some of the procedures contained in ACWD Letters No. 83-58 and 83-51. The areas in which procedures need to be modified are outlined below:

Consolidation of Notice, Application and Claim

A Beltran package shall be sent to those potential class members who, as of March 20, 1984: (a) had not been mailed a court-ordered Beltran notice; or, (b) had been sent the court-ordered notice but have not responded and are still within the 90-day time limit for response or who have responded but have not yet been sent an application by the county; or, (c) had been sent a Beltran application but have not returned the application form.

The package shall contain:

1. Beltran Application Instructions. This letter will be substituted for the Beltran Application Information Letter described in ACWD Letter No. 83-51. This will be sent only to those in (a) and (b) above.

2. The court-ordered Beltran notice. This will be sent only to those in (a) and (b) above.

3. The Beltran Application for Retroactive Coverage. This will be sent only to those in (a) and (b) above.

4. The Beltran Claim Instructions (Attachment III). This will be sent only to those in (c) above.

5. Six (6) copies of the new Beltran Claim forms. The new claim form has been revised to be completed by the potential class member.

Potential class members whose notices were returned indicating deceased or wrong address with no forwarding address will not be renoticed. Also, new packages will not be issued to those persons who previously responded but were determined not to be class members. It is not necessary to enclose a postage paid return envelope with the package.

Consolidation of Beneficiary Time Limits for Returning Documents

Under the present system, potential class members were sent the court-ordered notice and given: 90 days to respond indicating that they believed they were eligible for Beltran reimbursement; another 90 days to return an application; and then, 180 days to submit claim forms. Under the March 5, 1984 court order, all pertinent forms must be sent to the potential class members in one package. Time limits will run concurrently and the potential class members will have 180 days to return the application as well as the claim forms. The 180-day period begins with the date the class member receives these forms, even if they have previously received a court-ordered Beltran notice or Beltran application.

The Application Instructions and Claim Instructions encourage potential class members to return the application as soon as possible in order to have his or her retroactive eligibility determined in advance of submitting the claim forms. The counties must complete eligibility determinations on Beltran applications within the time limits specified in Title 22, California Administrative Code, Section 50177.

Please notify us in writing as to the date on which your county completes implementation of the new Beltran notice procedures required in this letter. This information must be provided by March 30, 1984, and should be sent to:

Marie Harder
Medi-Cal Eligibility Branch
Department of Health Services
714 P Street, Room 1692
Sacramento, CA 95814

If you or your staff have any questions regarding this matter, please contact Marie Harder at (916) 324-4956 or (ATSS) 454-4936.

Sincerely,

Original signed by

Caroline Cabias, Chief
Medi-Cal Eligibility Branch

Attachments

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health Ser

CO DIST | COUNTY USE

**BELTRAN V. MYERS — CLAIM FOR REIMBURSEMENT**

**READ INSTRUCTIONS ON BACK BEFORE COMPLETING**

| Only medical expenses in the following month may be listed below. | Your Share of Cost |
|---|---|
| ____ Mo. Yr. | $ ____ |

Name of claimant/beneficiary _____ Person acting in behalf of claimant _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Day phone _____ Day phone _____

County Code

Relationship to claimant _____

**Medical expenses of family members listed below may be included in this claim.**

| State Number: Aid | State Number: 7 Digit Serial No. | State Number: FBU | State Number: Pers. | Name — Last, First | Eligible in: A | B | C | Birthdate: Mo. Day Yr. | Sex | Other Cov. Code | Social Security No. | HIC or RR No. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

| | Date of Service: Mo. | Day | Yr. | Service | Total Bill | Paid By Patient | Paid By Other Source | Owed By Patient | STATE USE ONLY |
|---|---|---|---|---|---|---|---|---|---|
| Patient Name | | | | | | | | | |
| Provider Name | | | | | | | | | |
| Provider Address | | | | | | | | | |
| Patient Name | | | | | | | | | |
| Provider Name | | | | | | | | | |
| Provider Address | | | | | | | | | |
| | | | | | Total | | | | |

I understand that if I submit *unpaid* medical bills, Medi-Cal may pay the doctor or hospital.

I hereby certify under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

_____

Signature of claimant or person acting in claimant's behalf — Date

**STATE USE ONLY**

Date received _____ Notice of claim disposition sent: _____ Total reimbursement $ _____

Duplicate check _____ Initials _____ Date

Logged by _____ Initials

_____ Authorizing Signature

## INSTRUCTIONS TO CLAIMANT

1. Complete *one* form for *each* month in which you incurred medical expenses and for which you believe you are eligible for retroactive reimbursement. (If you need additional claim forms, you should contact the county welfare department.)

2. At the top right is a box to indicate what month the claim is for. Note the month for which you are listing medical expenses.

3. Next to the month box is a box labeled "share of cost." The county welfare department will complete this box when they receive the claim form. If your income for any of the months for which you are requesting reimbursement was more than the amount allowed for living expenses, you would have had a "share of cost" to pay toward the cost of medical care prior to receiving Medi-Cal. These amounts will be subtracted from the reimbursement amount owed you.

4. Name of claimant/beneficiary. Write the name and address of the person for whom reimbursement is being requested.

5. If you are completing the form for someone else, list your name and address after "Person acting in behalf of claimant" and tell us your relationship to that person (brother, sister, son, daughter) after "Relationship to Claimant."

6. You may include medical expenses for the spouse and/or minor children of the claimant/beneficiary. The "state number" will be completed by the county welfare department. List the name of the spouse and/or minor children, their birthdate, sex, and social security number if you are listing medical expenses for them.

7. The following corresponds to items on the front of the form:

| | |
|---|---|
| Patient Name . . . . . | Enter the name of patient to whom service has been provided. |
| Date of Service . . . . . | Enter *exact* date (month, day, year) each service was performed. Continuous service (such as hospitalization) should be shown as month, day, year THROUGH month, day, year. |
| Service . . . . . | Enter the type of medical care received (such as hip operation, nursing home care, physical examination). |
| Total Bill . . . . . | Enter the total charge for service. Do not enter in this space any amount paid by any other source, e.g., your insurance company. |
| Paid by Patient . . . . . | Enter the amount you have already paid. |
| Paid by Other Source . | Enter any amount paid by Medicare or other health coverage. |
| Owed by Patient . . . . . | Enter the amount that has not been paid. |
| State Use Only . . . . . | Leave this space blank. |
| Provider Name . . . . . | Enter physician, hospital, nursing home, or other person who provided your medical care. |
| Provider Address . . . . | Enter the complete address of the physician, hospital, nursing home, or other person who provided your medical care. |
| Total . . . . . | Leave these spaces blank. |

This claim must be accompanied by proof of payment of medical expenses. Acceptable proof of payment will be:

A. Copies of receipts (or bills stamped "PAID") from hospitals, skilled nursing facilities, physicians, dentists or other persons who provide medical care. The receipt submitted must show the beneficiary's name, the treatment or service, and the dates of treatment or service, or

B. Cancelled checks confirming payment to provider(s) for medical care received *and* a statement from the claimant itemizing the medical care received and the date(s) of service, or

C. A signed statement from the physician, hospital, or other person who provided your medical care. This statement must indicate the date(s) of service, the medical care received, and the amount paid or still owing by the beneficiary. The statement must also include the provider's name, address, and phone number.

8. After all documentation is attached, sign and date the statement verifying the information.

9. Do not write below your signature. This is for state use.

10. Return this claim form and proof of payment documentation to your county welfare department.

Beltran v. Myers
Application Instructions

Date: _____

State No: _____

District: _____

In a recent court decision called Beltran v. Myers we were ordered to notify you regarding your potential eligibility to have the Medi-Cal program pay for some of your past medical expenses. IMPORTANT -- READ THE ATTACHED NOTICE.

If you already received a notice advising you of the Beltran court decision, this letter replaces that previous notice and contains information and requirements that are different from the first notice.

To Apply for Retroactive Reimbursement

To determine your eligibility for reimbursement, you or your representative will be required to attend an interview with an Eligibility Worker. After we receive your application, we will schedule an interview for you and send you notification of the date and time you are to come in. At the interview, you may be required to provide verification of such things as the amount of income and resources you had and the type and cost of any medical services received and for which you request reimbursement. As such, you should only request retroactive coverage for those months in which you incurred medical expenses and for which you can verify the type of service received, its cost and how much, if any, you paid.

If you wish to apply for retroactive reimbursement, you must:

1. Complete and return the attached application.

2. Complete a Beltran Claim Form for each month in which you incurred medical expenses and for which you believe, or have been advised, you are eligible.

These forms must be returned to us within 180 days from the date you receive this letter. However, you may have your eligibility for these benefits determined before you submit the completed claim forms by first submitting the completed application form. Your eligibility will then be determined and you will be notified within approximately 45-60 days as to whether or not you qualify. You will then need to complete a claim form for each month for which you are determined eligible and in which you incurred medical expenses. REMEMBER THAT YOU HAVE ONLY 180 DAYS TO COMPLETE THE ENCLOSED APPLICATION AND CLAIM FORMS AND RETURN THEM TO THE COUNTY WELFARE DEPARTMENT.

If you have any questions contact the county welfare department.

Beltran v. Myers
Claim Instructions

Date: _____

State No: _____

District: _____

You recently identified yourself as a potential class member in Beltran v. Myers and requested an applicaiton so we could determine if you qualify to have the Medi-Cal program pay for some of your past medical expenses.

Although we have not yet received your completed application, we are required to provide you with the enclosed claim forms. You have 180 days from the date you receive this letter to return your completed application and claim forms to us.

You may have your eligibility for these benefits determined before you submit the completed claim forms by first submitting the completed application form. Your eligibility will then be determined and you will be notified within approximately 45-60 days as to whether or not you qualify. You will then need to complete a Claim form for each month for which you are determined eligible and in which you incurred medical expenses. REMEMBER THAT YOU HAVE ONLY 180 DAYS TO COMPLETE THE APPLICATION AND CLAIM FORMS AND RETURN THEM TO THE COUNTY WELFARE DEPARTMENT.

If you have any questions contact the county welfare department.